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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **REBECCA REINE DUNBAR** **914 Park Avenue** **San Jacinto, CA 92583** **Registered Nurse License No. 648291** Respondent.	Case No. 2013 – 122 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about November 19, 2004, the Board of Registered Nursing issued Registered Nurse License Number 648291 to Rebecca Reine Dunbar (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2012, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2811(b) of the Code provides, in pertinent part, that the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

7. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
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> . . . .

REGULATORY PROVISIONS

8. Title 16, California Code of Regulations, section 1442, provides:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

9. Title 16, California Code of Regulations, section 1443, provides:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

10. Title 16, California Code of Regulations, section 1443.5, provides:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of

the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL ALLEGATIONS

12. At all times mentioned herein, Respondent was employed as a registry nurse by Med Staff Healthcare Solutions. Respondent worked as a registered nurse at San Gorgonio Memorial Hospital (SGMH) in the Medical/Surgical Telemetry Unit on approximately five to ten occasions prior to September 18, 2008. Respondent was assigned to work the night shift in the Medical/Surgical Telemetry Unit at SGMH from approximately 18:00 hours on September 18, 2008 to 06:30 hours on September 19, 2008. As a nurse working through a registry, Respondent was responsible for orienting herself with the basic policies and procedures of the facility where she was working. As a registered nurse, Respondent was responsible for being aware of a patient's diagnosis, including fall risk, being aware of the patient's plan of care, monitoring the patient through direct observation or delegation, and ensuring that physician orders are promptly administered.

13. Patient A was admitted to the Medical/Surgical Telemetry Unit at SGMH during the day shift (0600 hours to 1830 hours) on September 17, 2008 at 17:25 hours. Patient A's admitting diagnoses included newly-identified weakness/paralysis, slurred speech, cerebrovascular accident (stroke) and hypertension (high blood pressure). Patient A's assessment report reflected that Patient A was to be on bed-rest, required assistance from the nurses and had a history of falls. The initial care plan contained a note on September 17, 2008 at 17:36 hours stating that Patient A was at risk for falls. The Morse Fall Scale[1] is an assessment tool used by S.G.M.H. to evaluate a patient's risk for falls. Patient A's score upon admission was documented as 45 (medium risk of fall) based on a history of a fall at home 1-2 weeks prior to admission. In addition, Patient A had a lower extremity weakness, a weak gait and an IV in place.

[1] A Morse Fall Scale score of 0-24 means that there is a low risk of fall, 24-50 means that there is a medium risk of fall, and 51 and above means that there is a high risk of fall. If a patient's fall risk is determined to be high, the nursing care plan is changed to reduce a patient's risk of falling.

14. At approximately 5:00 hours on September 18, 2008, Patient A fell in the unit.[2] The LVN assigned to Patient A at the time of the fall notified the physician's assistant, who performed an assessment, and documented the assessment in Patient's A's medical record in the Interdisciplinary Progress Notes.

15. During the shift change around 6:30 hours on September 18, 2008, the outgoing night shift did not orally report to the oncoming day shift staff that Patient A had a fall at approximately 05:00 hours on September 18, 2008. As a result, Patient A's plan of care was not modified, the fall risk score was not increased and the monitoring of Patient A appropriate to prevent a subsequent fall was not increased. There was no report of any unusual behavior by Patient A during the day shift from 0600 hours on September 18, 2008 to 1830 hours on September 18, 2008.

16. At the change of shift at approximately 18:00 hours on September 18, 2008, the day shift nursing staff gave an oral report to the on-coming night nursing staff assigned to Patient A, including Respondent. The oral report did not include any mention of Patient A's fall at 05:00 hours on September 18, 2008. Respondent was assigned as Patient A's registered nurse during the night shift from approximately 18:00 hours on September 18, 2008 to 06:30 hours on September 19, 2008.

17. During the night shift on September 18, 2008, Patient A was seen out of bed on at least three different occasions. Respondent requested a sitter to monitor Patient A but was informed by Charge Nurse Riqueza that a sitter was not available. At 20:00 hours on September 18, 2008, Respondent evaluated Patient A and determined Patient A's Morse Fall Score as 70. Respondent noted "side rails x 2" in the documented safety check of the patient's records. Respondent put up two bedrails on Patient A's bed because she believed two bedrails were considered a restraint.[3] Respondent obtained an order for a safety belt, soft wrist restraints, and

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[2] This fall occurred during the night shift from September 17, 2008 at 18:00 hours to September 18, 2008 at 6:30 hours, approximately thirteen hours before Respondent's shift began.

[3] Per SGMH's policy and procedures, four raised bedrails were considered a restraint (not two) and required a physician's order. Respondent could have used up to three bedrails without a physician's order.

Haldol at 21:15 hours.[4] Respondent notified Charge Nurse Riqueza of the order and asked that the physical restraints be provided. Respondent was unaware of where the restraints were kept and believed that Charge Nurse Riqueza would obtain the restraints which were located in the House Supervisor's office.[5] Administration of the chemical restraint, Haldol, was delegated to the assigned LVN. The assigned LVN did not administer Haldol to Patient A, because the patient was asleep at the time when the LVN went to administer the medication. Respondent did not follow up on the administration of the Haldol or the execution of the physician's order for restraints. The restraints were not applied to Patient A prior to 21:55 hours.

18. On September 18, 2008, at approximately 21:55 hours, Patient A was found lying face down outside his assigned room, the result of another fall. Patient A sustained serious physical and neurological injuries causing deterioration in the patient's physical condition. A CT scan of Patient A's brain after the fall confirmed subarachnoid hemorrhage.[6] Physical restraints were applied to Patient A after his fall at 21:55 hours.

19. Patient A was transferred to another facility on September 19, 2008 at 9:10 hours due to complications from the second fall. Patient A died on September 23, 2008 at 19:06 hours, with the cause of death listed as subarachnoid hemorrhage and blunt force trauma as the result of an accident.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence)

20. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a)(1) of the Code in that during her assigned shift at SGMH, Respondent was grossly negligent by failing to provide care which she knew or should have known jeopardized the patient's life, as is set forth in paragraphs 12 through 19 above, in that Respondent failed to administer chemical and mechanical restraints when caring for Patient A, who was at risk for falls, after the restraints had been ordered.

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[4] The Haldol was ordered "PRN" or "as needed" for agitation. The order states that staff "may use safety belt and wrist restraints for safety of patient."

[5] Staff were able to obtain the restraints with no checkout procedure.

[6] A subarachnoid hemorrhage is a bleeding in the brain.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Incompetence)

21. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a)(1) of the Code in that during her assignment at SGMH, Respondent demonstrated incompetence in her care of Patient A, as she failed to exercise the degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse, when she failed to obtain adequate orientation in SGMH's policies and procedures relating to restraints, as is set forth in paragraphs 12 through 19 above, which are incorporated herein as though set forth in full.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 648291, issued to Rebecca Reine Dunbar;

2. Ordering Rebecca Reine Dunbar to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: August 13, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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